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# Adolescents Pregnancy and Youth Friendly Services

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**ABSTACT**

The continuity of human existence greatly depends on the successful transition of the adolescents from childhood to adulthood. Sadly, most youths are not adequately informed in the matters of reproductive health. Consequently, they indulge in risky behaviors so much that their futures might be compromised. These risky behaviors became a public health menace and global concern thatInternational and National Health Agencies intervened by introduction of Adolescent Youth Friendly Health Services (AYFHS) to checkmate adolescent pregnancy and its poor prognosis. This paper was guided by aim and objectives, problem statement, reviewed points and methodology. A descriptive qualitative research design was adopted for the work, as relevant literatures were reviewed from the journals, bulletins and internet. Some variables were found to be major barriers to sub-optimal youth access and utilization of YFS in Nigeria. Based on the findings, recommendations were made to intensify to support the youth through dissemination of information, strengthening and sustaining YFS in primary health facilities so as to optimize access and utilization in Nigeria.

**Key words:** Adolescent Pregnancy, Youth Friendly Services, Sexual and Reproductive Health.

## 1.INTRODUCTION

Every human population is made up of young people, middle age and the old people. Among these, three groups, young people seem to have more population thanother groups on Population Pyramids of most countries.This group comprises of the adolescents (10-19 years); and the youths (15-24 years); who made up the "young people" (10-24years), group (Csikszentmihalyi, 2021).Theadolescentsare people between 10 and 19 years of age, (World Health Organization, 2020). United Nations International Children EmergencyFund also defined Adolescents as those between the ages of 10 and 19 (UNICEF, 2019). The National Guidelines on Promoting Access of Young People to Adolescent & Young-Youth Friendly Services in Primary Health Care Facilities in Nigeria (2014) also agreed with these age brackets. In a nut shell, adolescent starts from 10 years and ends at 19 years but aregrouped among the young people from 10 to 24 years age bracket. Amongst young people; adolescents are most likely to become pregnant and it has become a global burden due to numerous reasons.

Adolescence is a transitional phase of growth and development between childhood and adulthood (Csikszentmihalyi, 2021).This was agreed by Mohanty (2015), who add …, "with many developmental changes and challenges". He further stated that it is transitions from schools to the world of post secondary education, employment and life in general community as an adult.Adolescence therefore is a transformational phase or stage in life, from childhood to adulthood accompanied with unforeseen physical and psychosocial problems. Berman and Snyder (2016) posited that usually, adolescent accompaniesrapid physical, cognitive and psychological growth which predisposes a girl child to risky behaviors, early marriage and intercourse, religion and cultural practices.The accelerated physical growth in adolescents is influenced by some variables such as, hereditary, nutrition, medical care, illness, physical and emotional environment, family sizes and culture. Between the ages of 11 and 15, in formal operations stages, the adolescent becomes curious, inquisitive, idealistic and highly imaginative most times beyond realityPiagets cognitive development theory (1936) and this type of thinking requires logic, organization and consistency (Berman & Snyder, 2016).The adolescents build a world of their own which they might share with their peers or with whom they wish. They also acquire more information about their immediate environment and the world and apply the information to solve daily problems. All of these influence their social interaction leading to their parents misunderstanding their intents which often result to confusion, friction and conflict between them and their parents(Berman & Snyder, 2016).

Another factor that influences the adolescentsin their transitional journey explained by Berman & Snyder (2016) are the various developmental phases. Kohlberg (1984) theory of moral development in stage three", theyare faced with moral dilemmas, discarding their family values or the Golden Rules and abiding by the existing social norms and laws to gain approval as they build personal relationship.Erikson (1964)developmental theory which believes that life is a sequence of developmental stages and failure to complete any developmental stage influences the person's ability to progress to the next level. Each stage is filled with conflicts, stressors and storms. The ability to resolve them and move on to the next stage successfully breads a healthier and successful person who functions effectively in the society. But failure to resolve the conflicts damages the ego. Stages 3-5expresses howan adolescent struggles to establish occupational (industry), social interaction (identity)

sexual identity (intimacy), such as exploration of sexual images, fantasies, ideas and roles, experimenting with dress and language, dances, dating, youth activates etc. All of these help them to define who they are. This identity struggles, creates cliques and separate youth culture (Berman & Snyder, 2016). Conflicts may arise between behaving in an acceptable manner to the parents and peers. At about fifteen years, most adolescents gradually draw away from their parents to gain independence(Berman & Snyder, 2016). The need for independence and the need for family support clashes sometimes and create conflicts within the adolescent and between the families. The conflict "within" might lead to depression or hostile behaviors which might tilt theadolescent more towards their peers and parents avoidance.

The intense association with their peersmight brew risky behaviors such as Tobacco uses, Alcohol or drug use, unhealthy diet, physical inactivity sexual experimentationwithout condom, contributing to sexually transmitted infections (STIs), and Teenage (adolescent) pregnancies, (Berman & Snyder, 2016). The constant risky behaviors among young people such as substance abuse, sexual intercourse without condom, among others lead to increase in the number of unwanted pregnancy amongst the adolescents. Adolescent pregnancy was definedby several authorities; WHO, 2017 defined it as anoccurrence of pregnancy in female children aged 10-19. Adolescent pregnancy was also said to be the occurrence of pregnancy in girls aged 10-19 years with peculiar physical, social, psychological and reproductive health characteristics (Kassa et al. 2018).

Globally, adolescent pregnancy is a public health issue, with high adverse maternal and perinatal outcomes (Kassa et al. 2018). According to UNICEF (2019), 1.2 billion adolescents make up to 16% of the world population. 777,000 births take place among adolescent girls younger than 15 years in developing countries (United Nations Population Fund, (UNFPA 2013). In 2021, Agency UNFPA stated that 20,000 girls under age 18 give birth, which amounts to 7.3 million births a year. In U.S.A. adolescent pregnancy was 17.4 per1,000 females in 2018; 58.3 in 2019 declined by 4% (56.0) births per 1000 women in 2020 (Martin, 2021). In developing regions, an estimate of 20 million girls between 15-19 years becomes pregnant every year and approximately 12 million of them give birth of which 350 million lives in Asia; the Pacific has over 300 million, and for Sub-Sahara Africa, 23% of the region's population aged 10-19 years and 10% become mothers by age 16. (Darroch et al. 2016). Furthermore, adolescent group makes up one fifth of the entire population in Nigeria. In terms of child bearing before age 15, Nigeria ranks 5th and 15th in top 20 who have children between the age group of 15-18 years with highest in the North and lowest in the South-east and South-west (Aroma, 2018). The National Population Commission (NPC, 2019) stated that, adolescent birth rate in 2018 was 106 births per 1,000 women, with a high birth rate in the Northern West region where the median age of first marriage and first intercourse is approximately 16 years. Estimated 23% of women in Nigeria 15-19 years have bore children of which 17 percent have had their first child and 5% are pregnant with their first child they stated. Among the six geo-political zone of Nigeria, Northwest region accounts for 36%; Northeast 32%; North Central 19%; South South 12%; South East 8%; South West 8% DHS from NPC, (2013). The occurrence was noted to be highest in the North and lowest in the South-east and South-west.

Apart from the above mentioned demographicburdens, other problems such as: school dropout, increase in adolescent fertility rate, prevalence of STIs/HIV cases, maternal and morbidity rate of the girl child due to abortion, un/under employment and perpetual family poverty are other associated problems of unwanted adolescent pregnancy.

These problems necessitated the WHOcollaboration with UNICEF (United Nations International Education Fund), United National Population Fund (UNFP) and came up with an evidence-based intervention program called "Adolescent Youth Friendly Health Services (AYFHS)". It aimed to avert sexual and reproductive health problems of the youth (Csikszentmihalyi 2021). United Nation Women (UN Women) and Family planning 2020 also joined to end child marriage, and enable 120 million more women to access contraception by 2020.

## 1.1 Aims and Objectives:

The purpose of this paper was to highlight the components of the YFHS; determine barriers to access and utilization of youth friendly health services in Nigeria and their relationship with adolescent pregnancies. The overall objective was to investigate the impact YFS has made in the country, in other to make recommendations on youth availability, access and utilization

**Why AYFRHS?**Adolescent Youth Friendly Health Services (AYFHS)was an approach/a guide forState Government to improve the provision of adolescent and youth reproductive health services based on the needs of that 15-24-years-old. "YFS" was designed to address the barriers faced by youth in accessing high-quality sexual and reproductive health (SRH) services Merritt (2020).Youth friendly services provide sexual and reproductive health (SRH) services such as: counseling on sexuality, HIV counseling and testing, pregnancy testing, contraceptive provision, sexually transmitted infections screening and management, abortion care and other medical services.These services should be accessible, acceptable, equitable, and appropriate and effective for the youths as was stipulated by WHO's standard for adolescentunwanted pregnancy to be checked. This laudable program faces sub-optimal utilization due some barriers such as:Structural, Social, Individual and Lack of firm commitment by the Legislators.

## 1.2. LiteratureReview

Relevant literatures were reviewed and discussed undertwo main headings:

Adolescent Pregnancy

Youth friendly Services

1.2.1**Adolescent Pregnancy**

Adolescent pregnancy has been defined by several authorities; adolescent pregnancy was defined as occurrence of pregnancy in female children aged 10-19 (WHO, 2020). Adolescent pregnancy was also said to be the occurrence of pregnancy in girls aged 10-19 years with peculiar physical, social, psychological and reproductive health characteristics (Kassa et al. 2018).

**Causes:** Numerous reviewed literatures revealed contributory factors to adolescent pregnancy and its prevalence. According to Kassa et al., (2018) some socio-demographic factors that might cause adolescent pregnancy include:

Rural- Urban residence, educational status of both the mother and an adolescent girl i.e. not attended vs unattended, marital status of both mother and the adolescent girl, sexual violence, in developing countries, high unmet needs for contraception'samong adolescents in Sub-Sahara African countries, child marriage and lack of parent- adolescent communication on sexual and reproductive health (SRH) issues and marital status were mentioned by (Kassa et al. 2018). On this issue Brain, (2020) explained that it was a taboo to discuss sex related issues in some households. Financial autonomy was also seen as a contributory factor to high adolescent pregnancy in the community Brain, (2020). Some other factors included were poverty, child marriage, peer pressure, media influence and street hawking (Alabi, 2017).

**Consequences:** The outcome of adolescent pregnancy might not be favorable for both mother and child health as they might pay a great price for it. This is in line with WHO; Trusted Source, (2020) findings that adolescent pregnancy or child birth are major causes of global death of girls ages 15 to 19 years globally; and 99% global maternal deaths of women aged 15-49, risk of eclampsia among 10-19 years, peuperial endometritis and systemic infection is common amongaged 20-24, unsafe abortions among 15-19years, low birth weight, preterm delivery and neonatal complications.

Socio economic consequences stated by Carey (2018), include:isolation, perpetual poverty due to un employment, depression, adoption. The boy might be registered as a sex offender; he might also have difficulties staying in school.Abortion was considered as one of the consequences of adolescent pregnancy due to either unreadiness of the partner to assume responsibility for the girl and baby or if the girl is doing well at school (Brain, 2020). Other consequences mentioned by Carey (2018) include: adoption of the baby by capable hands.

The health effect could be: For the babies; likelihood of being delivered prematurely, underweight, difficulty in breathing and feeding, improper brain development and learning difficulties, susceptibility to diabetes, heart diseases and death Carey (2018). For the mother: high risk for pregnancy induced hypertension (preeclampsia), anemia, harm to kidney and fatality to mother. For the partner; he may face difficulty staying in school and earning a living. In some developed countries, he may be registered as a sex offender if his partner has not reached a legal age of 18 and he is (Carey, 2018).

In 2018, Kessa at al., did a systematic review and meta analysis of the prevalence and determinants of adolescent pregnancy in Africa and presented these results: Rural residence: Never married (OR: 2.04), Not attending school (OR: 20.67), No maternal education (OR: 2.49), No father education (OR: 1.88). Poor communication on sexual and reproductive health issues (OR: 2.88). They concluded that: They concluded that adolescent pregnancy causes intergenerational cycle of poverty and there was high (99%) maternal and child morbidity and mortality among women aged15-19 in Sub-Sahara African countriesKassa et al. (2018).

**Prevention**

Abstinence-centered sexual education is effective in preventing adolescent pregnancy(Carey, 2018). However, there are other means of preventing adolescent pregnancy such as: Improvement of contraception access, adolescent health friendly access and sexuality education(Brain,2020)Peer counseling was also advocated since it might be comfortable confiding in someone their age; some communities and information centers may offer group counseling on birth control and help them understand their sexual limit. Furthermore, birth control methods such as intrauterine devices device (IUCD) has 99% rate of effectiveness, implants, patches, pills and male/female condoms could be used (Carey, 2018).

Adolescent should be made to be aware of high risk of the cycle repeating itself once the baby grows to be comes a teen, lowered job attainment, lower educational achievement, health risk and possible deaths. They should be given adequate sex education as early as possible in life to enable them male informed and responsible decisions about their sex lives.

1.2. **Youth friendly Services**

Youth Friendly and Reproductive Health Services are either services or clinics that offer comprehensive sexual and reproductive health services in a way that are responsive to the specific needs vulnerabilities and desires of young people(Souwman, 2022).Adolescent Youth Friendly Health Services (AYFHS) was designed to address barriers faced by youths in accessing high-quality sexual and reproductive health services (Merritt, 2020). Youth Friendly Reproductive Health services are services that are accessible to and acceptable by and appropriate for adolescents and youth (Open University London, 2022). Sexual & reproductive health and rights are human rights related to sexuality and reproduction which allows people to make informs and meaningful decisions about their sexual well being, such as sexual orientation relationships, sexual activity, family planning or their bodies (Souwman, 2022). These services should be appropriate i.e.; suitable for the adolescents and the youths, acceptable (embraced by them), accessible (awareness and the ability of adolescents and young people to obtain the available health services Federal Ministry of Health, 2014), equitable (to all adolescent, regardless of their age, marital status, HIV status, sexual orientation, gender identity, occupation, social status, geographical location, or ability to pay Amsterderm, 2022).According to Souwman in 20220, these services should rendered based on confidentiality, non judgmental and private. Therefore, theeffectiveutilizationdepends on the ability of theseservices to meet their sexuality and reproductive health needs.While planning the adolescent program and services, it is important for the

adolescents/youthsto be involvedin their service discharge in both schools and clinics. AYFRHS recognizes the people and community that structures one's life; such as spouse, and significant others, mother-in laws, guidance, faith organizations, clinics and schools (Souwman, 2022).

**Services found in AYFRH Program:**

Adolescent Youth Friendly Reproductive Health Services should be implemented according to the WHOstandard. The services are:

**Sexuality education**. Youths should be given a comprehensivesexuality education(CSE) informationabout their sexual and reproductive health which should be age and developmental appropriate and scientifically accurate (Wash, 2018). Sexuality education should be included into the school's curriculum so as to empower the youths on sexual reproductive health rights, knowledge, life skills they need to make informed decisions on their sexuality in other to protect their health, well-being and rights. Further steps was suggested to improve sexuality education such as establishing multi-sectoral group champions, developing a curriculum grounded in young people's reality, train and support educators to deliver rights-base CSE.

Community gatekeeper; these are people who have influence or control over youth access to health care, eg husbands, parents, mother-in-laws, religious leaders, male relatives etc, should also be sensitized (Merritt, (2020).

**Contraceptive provision**: Family planning information, counseling and methods appropriate for them. Birth control methods such implant, IUCD, Patches, diaphragm, condom or Oral contraceptive method should be discussed.

**STIs/HIV and Pregnancy testing:** Among the services provided in YFRHS, STIs/HIV pre and post test and counseling, should be done, and treatment commenced promptly to avert further spread and complications. Where free treatment is possible, it should be administered.

**Pregnancy testing**was also one of the services rendered to the youths in YFRHS (Open University London, 2022).

**Abortion care:**Abortion and post abortion care are other services included inYFRH program.**Other medical services:** Other medical services included in this package are: Antenatal care, delivery, postnatal care, Prevention of Mother to Child Transmission (PMTCT) and appropriateintra or inter facility referrals (Open University London, 2022).

**Benefits:** These are some benefits of YFS as presented by Merritt, (2020).

YFS facilitates youth's access to and satisfaction with health needs services.

Institutionalize use of YFHS standards in routine MOH quality improvement/assurance supervisory visits.

It delivers higher quality SRH services to youth.

YFHS empowers health providers to be advocates for youth.

It also encourages future health-seeking behavior among youth.

## 1.3. Barriers to YFRHS access, availability and utilization

Barriers are problem, rule or situation that prevents somebody from doing something or that make something impossible. E.g. lack of confidence is a barrier to success (Oxford advanced learners dictionary, (2001).Therefore, structural, social and individual barriers might make access, availability and utilization of YFS impossible.

**Structural barriers**

**Structural barriers:**are obstacles that collectively affect a group disproportionately and perpetuate or maintain stark disparity in outcomes, it can be polices, practices and other norms that favor an advantaged group while systematically disadvantaging a marginalized group (Simm et al,. 2015). In a plain language, any situation or event that makes it difficult to obtain a needed service is a structural barrier. They could be: infrastructure, transportation, clinic and appointment time, and inability to pay bills and health insurance. There are hidden barriers such as lack of knowledge about local health care services, non-physician gatekeepers, and fear of medical care (Freed, et al., 2014). This assertion was evidenced by the integration of a National Standard and Minimum Package for AYFHS and National Guidelines for Integration in Primary Health Care (PHC) in 2012-2013, yet the utilization remains sub optimal due to personal consideration and community based barriers (FoM H2021).

Adolescents face so many structural and utilization barriers in accessingand utilization of RHS in Nigeria, probably due to open or hidden structural barriers. Some of these barriers are: laws and policies which require partner or parents consent, distance from facilities, cost of services/transportation, long waits for services, in convenient hours, lack of necessary commodities at health facilities and lack of privacy and confidentiality, providers are bias about adolescents (unmarried) accessing contraceptives (Gates et al., 2022). Structural barriers in health context could be anyobstacle that detersa group or individual from access and utilization of available health care services.

Nmadu, et al., (2020) carried out a study in January, 2017 and April, 2017 on Barriers to adolescent access and utilization of reproductive health services in community in North-west Nigeria. The aim of the work was to explore the barriers hindering adolescents' access to utilization of RHS in Primary Health care. The result revealed that some barriers to access and utilization of RHS by young people was health system factors (privacy and confidentiality; community members, negative attitude of the health care providers, such as being hash and not considerate, facility opening hours coinciding with the school hour, unavailability if prescribed medication or commodity, lack of equipment, educational materials or infrastructure: inadequate space, lack of staff etc).This shows that adolescent access and utilization of RHS might be affected by structural barriers especially in some rural areas where topography is not favorable and clinic often start late, or the consultants or care providers are not

regular.

**Social barriers**

Social barriers are said to be the inequalities that exist between different individuals in a society, created by culture of a community and influenced by the behavior of the people (Bashin, 2020).

Socio-cultural barriers are man-made constructs originating from social norms and cultural values. Social barrier therefore are unfavorable cultural practices (Norms/Morals) that prevents certain groups from achieving their goals. Some social-cultural barriers are: language barrier: Nigeria comprising of a multi lingual and ethnic groups might face communication barriers due to language disparity which makes access to information difficult. This type of barrier in delivering youth friendly services, in regions where literacy level is low and vernacular are spoken fluently even in the classroom would place the adolescents who are in dare need of information regarding reproductive health services in a difficult position because they might feel shy and intimidated to speak to a care provider in a local dialect. Others include Social stigma, Cultural taboos, organizational, institutional, Socio-economic. A study carried out by Savolainen, (2016) on approach to socio-cultural barriers to information seeking, concluded that social barriers have many faces and determines the extent to which people can access information. Confrontation with socio-economic barriers could adversely affect information seeking and restrict access. Financial constraints related to unemployment determine a family's social status. Teenage girls from such families are susceptible to early marriage and adolescent pregnancy due to poverty, inadequate health care and other basic daily living needs.Religious influence: societal norms and morals are greatly influenced by religion and contribute to sub-optimal access and utilization of YRHS especially in Muslim communities where women stay indoors, discussions of sexual matters are seen as immoral, not included in school curriculum, and most decisions are made by husbands. Religious taboos which forbid adolescents from openly discussing sex and reproductive health issues, especially in Muslim community where Islam forbids the use of contraceptives and sees it as immoral is a strong factor. Other barriers dictated religion includes preference to service providers of same sex, transportation cost and inability to pay for services etc. (Savolainen, 2016). These limit the young girls from information sources and fuels ignorance.Adolescent fertilityrate seems higher in the North and ruralareas more than the urban areas because of these reasons.

**Individualbarriers**

Individual factors were lack of knowledge by the youth incomplete or incorrect knowledge of SRH, myths and misconceptions, individual perception, shame and stigmatization Elnimeiri, (2020).Other identified factors are: individual barriers to utilization include: misconception about contraception, and believe that contraception was for married people alone, limited knowledge of types of contraception and available RHS, lack of confidence in discussing personal problems even with a consulting staff, delay in taking action when faced with RH problems Nmadu, et al., (2020).Several works on barriers to access and utilization of youth reproductive health serviceswere reviewed by Elnimeiri et al., (2020) and reported thus: utilization level of adolescents/ YFSRH was 35% in Southern Africa, 21.5% in Ethiopia, 75% in Lagos, Port Harcourt 89%. 67% of youth in primary health care facility in Ethiopia did not know about AYFRHS. The above reasons explained why the prevalence of adolescent pregnancy persists.

**Lack of firm commitment by the legislators**

Customary and religious laws are impeding progress towards women's health in Nigeria McGovern, etal., (2021). Maputo protocol in 2003, (a human right instrument that address gender inequality and abuse against African women such as discrimination in education, child marriage, sexual and reproductive health rights, legal abortion among others), was signed by Nigeria, but was not domesticated due to the delay in passing of gender and equal opportunity (GEO) bill of 2016 (an amalgamation of principle bills and provisions CEDAW and Malputo Protocol which prohibit all forms of discrimination) Alliance For Africa, (2018). The reason was due to lack of firm commitment by the legislators, as was noted in the report of 62 ordinary Session of the African Commission on Human and People's Rights (ACHPR) by Alliance for Africa (AFA, 2018). Another reason is the diversities in Sharia Schools/court; based on the jurists' allegiance to the founder, decisions are made regarding female reproductive health rights. Women who gotpregnant outside marriage have been convicted of zina (unlawful sexual intercourse; a crime against god in Quran) andsentenced to death. To avoid threat to their lives, such women may resort to illegal abortions and possible complications or death (Imam, 2019).

**Efforts made to make healthsectors youth friendly**

Every country has its own guideline drawn from the principle laid down by the World Health Organization. According to WHO, in 2006, to make youth friendly accessible for the youth, government run hospitals are re-orientated, services are provided in the hospital, public and private, NGO clinics, work places, shopping centers, refugee camps, pharmacies, youth centers, educational institutions and even on the streets To overcome the barriers and huddles adolescents jump to access health services, the following efforts are being made:

Health care providers should not be non-judgmental, they must be competent to provided the needed services in the right way

Health facility should be equipped to provide the adolescents with the services they need in an appealing and friendly manner.

Adolescents should be aware of where to obtain services when need be

The community members should not only support the adolescent in time of health service needs but should also be aware of where to get the needed help WHO.

## Conclusion

The global prevalence of adolescent pregnancy and its socio-economic impact spurred the international health agencies to establish youth friendly services that would take care of youth reproductive health problems. Same program has trickled down to various countries all over the world. Its success story revealed that adolescent pregnancy has declined in developed countries but sadly high in developing countries with Sub-Sahara Africa leading. Several factors were identified to have contributed to poor access and utilization ofYFRHS and high adolescent pregnancy in under and developing countries such as: individual, structural and social barriers which embed other barriers. Legislature's sentiments impeded the domestication of bills that protect women's right, religion and socio-culturalinfluence on the communities and its gate keepers. Therefore, for effective utilization of the youth friendly services, it is,necessary to involve every stakeholder in the implementation of this laudable program irrespective of where it is situated.

Conclusively, the studied variables should be considered when planning interventional programs for YRHS, or re-strategize so as to improve the level of access and utilization of YFS in the health facilities otherwise, the goal YFS might not be achieved and youth availability might continue to dwindle resulting to sub-optimal access and utilization of the youth friendly reproductive health services and increase in adolescent pregnancy.

**Recommendation**

Based on the findings of this work, the following recommendations are made:

1. The Federal Ministry of Heath should encourage the access and utilization of YFS by a lunching a mandatory nationwide YFS campaign in the media, schools and universities to reach the youth.
2. Youths should be involved in planning and implementing their program.
3. Program mangers and stake holders should ensure commodity and service availability for the youths in every State, Local Government and Communities especially the rural areas where adolescent pregnancy are more.
4. Protocols and Bills relating to women's right should be domesticated in all states to protect and promote women's right to enhance women empowerment concerning their health.
5. Further study should be carried out on both variables with more attention to adolescent prevalence in the rural communities.

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